STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08E029	A. BUILDING _____ B. WING _____	C 06/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVERNOR BACON HEALTH CENTER	P.O. BOX 559 DELAWARE CITY, DE 19706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual survey and complaint visit was conducted at this facility from June 1, 2010 through June 9, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was eighty-seven (87). The survey sample totaled thirty-seven (37) residents.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it	F 279 **Immediate Corrective Action**	1) The resident's care plan was immediately reviewed and a unit of care was added for falls. 2) The resident's care plan was immediately reviewed and a unit of care was added for alteration in thought processes: Schizophrenia and other Psychotic Disorders. **Identifying other residents having the potential to be affected** 1) All residents' plans of care were reviewed for risk of injury related to falls. 2) All residents' with a psychiatric diagnosis care plans were reviewed to ensure compliance. Plan of Correction In-service completed for both items above.	June 9, 2010 June 9, 2010 June 8 thru July 7, 2010 June 30, 2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Director | (X6) DATE: 7/2/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 was determined that the facility failed to develop care plans for the assessed care area for two (R27 and R36) out of 37 sampled residents. The facility failed to implement a care plan for potential for fall with injury after R27 experienced an actual fall in which the resident sustained a laceration of the forehead requiring emergency care and suturing of the wound. R36 was diagnosed with Schizophrenic disorder for which the facility failed to care plan. Findings include: 1. Cross refer F323, example #1. Review of the annual MDS assessment for R27 dated 11/16/09 indicated that the resident was in a comatose state, required total assistance for all ADLs, had no problem with trunk control while in the wheelchair, and had experienced a fall within the past 30 days. Based on this assessment, the resident triggered on the RAP (resident assessment protocol) summary for problem area of fall and was documented that this was addressed in the care plan. Although the above MDS assessment indicated that the problem of fall was care planned, review of R27's Interdisciplinary Care Plan (ICP) dated 11/18/09 failed to care plan the potential for fall or potential injury secondary to a fall. Interviews with both E4 (unit manager) and E3 (Assistant Director of Nursing) on 6/9/10 at approximately 9:30 AM revealed that since the facility assessed this as an accident, they did not feel there was a need to implement a care plan, thus, the care plan was never implemented. In addition, R27 was not assessed for further fall risk due to her persistent vegetative state. However, during the survey the facility determined the need to implement a care plan for potential for	F 279	Systemic Response All the residents care plans were review for potential for injury r/t to falls and for correct psychiatric diagnosis and interventions. GBHC as always will continue to review all residents' plans of care quarterly. A fall prevention policy/procedure will be developed. Monitoring GBHC Nursing Department will randomly audit/monitor the resident's care plans for accuracy. This report will be submitted to the QA committee monthly.	6/8/10 and ongoing July 23, 2010 June 14, 2010 and ongoing

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F 279	Continued From page 2 injury related to fall and the surveyor was provided a copy of a care plan at approximately 1 PM on 6/9/10. The care plan interventions included 1) assess for risk of fall and to consult physical therapy if resident experiences a fall; 2) When R27 is fed her meal in bed, that staff should be with the resident and the resident will not be left alone. In addition, that staff are to ensure that the head of her bed is maintained at 30 degrees angle, the bed placed in the lowest position. 2. R36 had a psychiatric diagnosis of Schizophrenia. Review of the care plan revealed the facility did not develop a care plan for R36's diagnosis of Schizophrenia with interventions that included the use of Zyprexa and the monitoring of the side effects for this psychoactive medication. Interview with E14 (LPN) on 6/4/10 at 1:48 PM confirmed the facility failed to develop a care plan for R36's diagnosis of Schizophrenia which included appropriate interventions.	F 279		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility	F 323 Immediate Corrective Action	1) During care on 10/19/09, a CNA left the resident unattended at bedside to answer a personal emergency call. After the fall incident, GBHC immediately removed the CNA from direct patient care. GBHC completed a neglect investigation and forwarded to the Division of Long Term Care Residents Protection who substantiated as patient neglect. The CNA later resigned in lieu of termination.	Oct. 19, 2009 Oct. 23, 2009 Jan. 15, 2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 3 documentation, and interviews, it was determined that the facility failed to ensure that two (R27 and R58) out of 37 sampled residents received adequate supervision to prevent accidents. R27 was left unsupervised in the bed and fell out of bed sustaining a 2 centimeter laceration on the right side of her forehead which required hospitalization for the nine sutures to close the laceration. R58 had a history of elopement prior to coming to the facility and was able to elope in 2009 and again in 2010. Findings include: 1. R27 was originally admitted to the facility on 10/2/03 with diagnosis including persistent vegetative state, dementia with depression and psychotic features and Alzheimer's disease, hypertension, and irritable bowel syndrome. According to the quarterly MDS (Minimum Data Set) assessment dated 8/17/09, R27 was in a state of coma (persistent vegetative state/no discernable consciousness) and was totally dependent on facility staff for all ADLs (activities of daily living). Also, R27 did not have any accident within the past 180 days. Review of R27's ICP (Interdisciplinary Care Plan) dated 8/19/09 indicated that R27 required two staff members to assist with Vanderlift (a mechanical lift device used for transferring resident) only while in seated position due to R27's bilateral knee flexion contracture. A nurse's note dated 10/19/09 timed 8:10 AM documented that R27 was observed laying on her right side on the floor with a large gash noted on the right forehead. Further review of the nurse's note revealed that R27 was sent to the hospital and received nine sutures to close the 2	F 323	2) GBHC strives to promote residents' level of independence and enjoy optimal freedom in a safe and secure environment. A resident, who eloped from the facility, had ground privileges at the time of the incident. Resident had been at GBHC for a little over a year without a previous attempt for leaving the grounds without permission. Resident was returned to facility with no injuries or other adverse effects.	April 25, 2009
		Identifying other residents having the potential to be affected	All residents' plans of care were reviewed for risk of injury related to falls. All residents' plans of care were reviewed for risk of injury related to elopement.	June 8, 2010 and ongoing
		Systemic Response	All residents' plans of care will be reviewed quarterly. GBHC continues to track all incidents involving residents and GBHC in-services continue to educate and train staff in proper supervision of residents. In-service training on Safety measures for Residents in a Long Term Care Facility, Fall Prevention & LTC policy/procedures r/t use of personal electronic devices & cell phones was completed shortly after the incident occurred. This training will be repeated for all nursing staff as part of the Plan of Correction.	June 8, 2010 and ongoing October 20 – 23, 2009 July 12, 2010

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F 323	Continued From page 4 centimeter laceration on the right forehead. Review of the facility's "Incident Report", dated 10/19/09, revealed that (E16), a certified nursing assistant, while feeding R27 at the bedside received a personal emergency call and left Resident #27 in an upright 90 degree angle in the bed unattended to answer the call. Two other CNAs were feeding two different residents in the same room and did observe the resident falling to the right side then onto the floor. Per the incident report, E16 exited the resident's room less than two to three minutes prior to R27's fall. An interview with E17 (physical therapist) on 6/8/10 at approximately 2 PM revealed that due to R27's poor trunk control, the resident sat in a customized wheelchair for positioning. E17 further related that the physical therapy department is consulted for residents who are at risk for fall or had experienced a fall. However, they were not consulted for a fall from the bed to a lower surface, such as in R27's incident. Lastly, E17 related that due to R27's poor trunk control and bilateral knee flexion contractures, leaving the R27 unattended in bed at a 90 degree angle would likely result in the resident's body, by gravity, leaning to right or to the left and would leave the resident in an unsafe environment. Findings reviewed with administration on 6/9/10 at approximately 1:30 PM. 2. R58 was admitted to the facility on 3/4/08 with diagnoses that included Alzheimer's Disease, Cerebral Vascular Accident, Dementia other than Alzheimer's Disease, Parkinson's Disease, Traumatic Brain Injury from a ruptured Aneurysm, Bi-polar disease, Chronic Obstructive Lung Disease and Seizure Disorder.	F 323	**Systemic Response (continued)** Security staff will continue to check and test WatchMate system each shift to ensure that doors lock properly. If problems are identified, Security will alert Maintenance department who will fix the problem. Maintenance department will contact the contractor who provides overall support of GBHC's Pro-Watch/WatchMate system for any problem that cannot be fixed by GBHC staff. When a problem with a WatchMate door is identify, Security staff will change the door setting to continuous lock mode until the door is repaired. **Monitoring** GBHC Nursing Department will randomly monitor staff for compliance in supervising residents. GBHC DMS group will check the Watchmate system daily for correct operation. Maintenance department will maintain record of service and repairs of Pro-Watch/WatchMate system both in house and outside contractor. Reports will be submitted to QA committee monthly.	June 14, 2010 and ongoing June 9, 2010 and ongoing

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F 323	Continued From page 5 The MDS, dated 3/4/09, stated that R58 had short and long term memory problems, modified independence with daily decision making, and that he was independent with ambulation and transferring both on and off the unit. The 3/4/09 history and physical stated, "the patient was admitted to (facility) on 3/4/2008. He came to us from (another facility) where he had been a patient since 2005. Apparently he was a flight risk and a wanderer, unable to control his behavior. ....he was transferred here." The physician wrote an order dated 3/2009 "Pt. is allowed ground privileges with staff monitoring". R58's care plan, dated 3/4/2008, stated "General Care Needs Goal-Assess self care ability Intervention-R58 has a Watchmate bracelet #85 on left ankle. Maintain and check each shift." (This bracelet was later discontinued because R58 did not demonstrate exit seeking behaviors.) R58's care plan for 3/11/2009 stated "Potential for injury r/t wandering behavior Goal-Resident will be able to be move in a safe environment. Approach- Do not restrict mobility but redirect or escort to safe area/activities. Assess need for specialty unit or stroll control bracelet (Watchmate bracelet)..." The nurses notes documented on 4/5/09 at 2:40 PM "Resident noted outside ambulating without staff by security. Resident returned to nursing unit by staff. 1:1 provided related to safety. Resident verbalized an understanding." The functional care summary for R58 also documented this incident. R58 was found outside without knowledge of the staff. The facility did not apply a Watchmate bracelet on R58.	F 323		

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F 323	Continued From page 6 On 4/25/09 at 11:10 AM the nurses notes documented "Security called unit asking if R58 was up here and said that an employee had just seen him ambulating on... (a road that leads to a 4 lane interstate highway). A search of facility was conducted with no results. Security went out to get Resident ..." Resident ambulated to unit with security. Watchmate #067 was applied to right wrist by supervisor without incident. No injury noted or observed." On 3/8/10 R58's MDS documented his cognitive skills for daily decision making had declined stating he was moderately impaired (decisions poor, cues/supervision required). The MDS also documented R58 had wandering behaviors that occurred daily and were not easily altered. On 4/8/10 at 12:10 PM the nurses notes stated for R58 "At approximately 11:20 AM received call from (facility) staff member while they were out of the facility for lunch. They stated resident was on the (bridge) just outside of the upper gate to (facility) grounds. Security was also aware. Nursing supervisor left to pick resident up. Resident was across from (company) on the sidewalk with 4 other staff members. Resident refused to get in the car with them. Resident entered nursing supervisor's car without incident and was returned to facility. No injury noted to resident. Watchmate present on right wrist. Re-entered building near dietary entrance and Watchmate did alarm... Upon checking of Watchmate system by security, resident Watchmate (#44) registered at 11:10 AM from the door across from the activity room..." On 6/10/10 at 9:40 AM E14 (telephone operator)	F 323		

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F 323	Continued From page 7 was sitting at the desk across from the main entrance door located in the basement. E18 (LPN) was observed with another resident near the entrance of the door. The door did not lock. The resident was able to exit through the door before the alarm sounded or the door locked. By the time E14 stood up from behind the desk the resident was out the door and through the second door with E18 with him. On 6/8/10 at 1:30 PM E2 (DON), E3 (ADON), E11 (QA) and the surveyor toured the facility and checked every door that exited to the outside. A Watchmate bracelet was put in E3's sock for testing. Through this process it was identified that the door located outside the activity room was permanently locked. The door across from the elevator did not close properly. E3 was able to open the door and exit the facility. The alarm sounded when she was going through the door but the door did not lock. The same problem was identified with the door by the kitchen. E3 had maintenance observe the doors. There was a dark residue on the metal and the magnet that prevented the door from closing tightly and locking. The metal was cleaned and the door locked appropriately. The front entrance door did not lock when E3 came near it or when E3 opened the door. E3 was able to exit the facility however the alarm sounded. It was identified that the sensitivity of the Watchmate was to low. The low sensitivity kept the door from locking when E3 went near the door. Review of the environmental inspections performed by Division of Management Services revealed the doors and the Watchmate system	F 323		

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F 323	Continued From page 8 were checked monthly. E3 (ADON) and E11 (QA) stated on 6/8/10 that the Division of Management Service had the guards check the system every shift. Observations and documentation revealed that even though it was documented that the Watchmate system was checked the facility failed to identify the problems with the doors not closing completely which kept the system from functioning properly. Nor did they identify the lack of sensitivity at the main entrance door keeping it from locking when a resident with the Watchmate bracelet on approached the door. Interview with E11 (QA) on 6/9/10 at 10:55 AM revealed when R58 was admitted to the facility in 2008 he had a Watchmate bracelet on. R58 did not present any elopement behaviors so the facility removed the Watchmate bracelet in early 2009. E11 stated she was not notified that R58 was found outside on 4/5/09 without staff. When R58 eloped the facility on 4/25/09 a Watchmate bracelet was immediately applied. When R58 exited in April 2010 he had the bracelet on when he exited the door by activities. Someone deactivated the alarm without insuring that a resident had not exited the building. After the incident occurred E11 asked the staff from Division Management Service if they checked the Watchmate system. E11 was assured the system and doors were functioning properly. Upon further discussion on 6/9/10 with E11 (QA) it was determined that the facility had 15 residents that were wearing Watchmate bracelets. These residents were assessed for being at risk for elopement. The facility failed to provide supervision for R58 who had a history of elopement. The facility failed	F 323		

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F 323	Continued From page 9 to supervise R58 in April 2010 allowing him to elope from the facility. The facility also failed to ensure that a resident had not eloped from the facility after deactivating the Watchmate alarm. The facility failed to ensure that the doors and the Watchmate system were working properly and failed to ensure the safety for all residents who were at risk for elopement.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		
		Immediate Corrective Action	Physician reviewed the Ativan order and discontinued it on 6/8/10.	June 8, 2010
		Identifying other residents having the potential to be affected	All residents receiving an anti-anxiety medication care plans were reviewed. No other resident was identified as receiving an anti-anxiety medication without a care plan including monitoring and indication of use.	June 10 thru 30, 2010
		Systemic Response	All residents receiving an anti-anxiety medication will have their respective plan of care reviewed and updated quarterly. GBHC continues to educate and reinforce having an adequate indication for a medication usage.	June 8, 2010 and ongoing
		Monitoring	GBHC Nursing Department will randomly audit/monitor the resident's care plans for accuracy. This report will be submitted to the QA committee monthly.	June 14, 2010 and ongoing

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F 329	Continued From page 10 Based on record review and interview, it was determined that for one (R57) out of 37 sampled residents, the facility failed to have the resident's drug regimen free from unnecessary drugs. R57 was receiving an anti-anxiety medication (Ativan) without behavior monitoring and without an indication for its use. Findings include: R57's 5/12/10 Physician's Order Sheet (POS) noted an order for Ativan (anti-anxiety medication) .5 mg. (milligram) every 8 hours. Review of the May 2010 and June 2010 Medication Administration Record revealed that R57 received Ativan as ordered. Review of the 5/12/10 Interdisciplinary Care Plan revealed that the behavior symptom of socially inappropriate behavior, for which Ativan was utilized, was no longer a problem, thus, this was discontinued from the care plan. In addition, the monitoring of this behavior symptom was discontinued on 5/12/10. An interview with E4 (unit manager) on 6/8/10 at approximately 2 PM confirmed that the resident no longer had a behavior problem for which Ativan was being administered and that the facility was no longer monitoring these behaviors, although the resident continued to receive the Ativan. Subsequent record review on 6/9/10 revealed that Ativan was discontinued for R57.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364 Immediate Corrective Action	Dietary Director met with staff to review findings from the licensing survey. To ensure food is maintained at the appropriate temperatures, staff directed to immediately transport food carts to nursing units after trays are loaded; to keep cart doors closed until nursing staff begins serving residents, and to take food temperatures of test trays on	June 9, 2010 and ongoing

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F 364	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, and review of resident council meeting minutes, it was determined that the facility failed to serve food that was palatable and at acceptable temperatures. Findings include: Review of resident council meeting minutes, dated 4/9/10 and 5/12/10, revealed that residents complained breakfasts were served cold. During stage 1 resident interviews, 8 of 11 residents interviewed stated that their meals were not always served at the proper temperatures. On 6/7/10 at 7:10 AM, an open cart with breakfast trays was observed in the North 1 hallway. Staff were observed taking trays one by one and serving them to residents with the cart doors left open. At 7:50 AM, the last tray was served at which time temperatures were taken of food from a test tray. The coffee was 119 degrees and the oatmeal was 118.5 degrees and both tasted lukewarm. The pureed omelet was 93.7 degrees and the pureed sausage was 92 degrees and both tasted cool. The milk was 60 degrees and did not taste cold. The meal was unpalatable due to the food temperatures. Second floor observations on 6/7/10, revealed the breakfast cart sitting in the hallway at 7:36 AM with the doors left open as staff served residents. The last tray was served at 7:51 AM at which time temperatures were taken of food from a test tray. The oatmeal was 117.8 degrees and tasted lukewarm. The eggs were 89.7 degrees and the scrapple was 90 degrees. Both tasted cool. The	F 364	regular basis after residents are served. Dietary staff also stopped placing cold beverages on trays with the hot foods. Cold beverages are transported separately with ice to ensure cold temperature and staff will place these beverages on the food trays immediately prior to residents receiving their meal. **Identifying other residents having the potential to be affected** All residents are potentially affected by this deficiency. **Systemic Response** Dietary staff will continue to follow the aforementioned changes for preparing, transporting and serving food and beverages, as noted above, to ensure proper temperatures. Dietary staff will continue to take and record food temperatures of test trays on a weekly basis. In-service training will be presented to staff on maintaining and serving food at the proper temperatures. Dietary department has ordered and waiting delivering of Cambro system that has the capability to maintain proper food temperatures up to 90 minutes.	June 9, 2010 and ongoing June 9, 2010 and ongoing July 12, 2010 July 23, 2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08E029	A. BUILDING _____ B. WING _____	C 06/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVERNOR BACON HEALTH CENTER	P.O. BOX 559 DELAWARE CITY, DE 19706

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F 364	Continued From page 12 milk was 54.5 degrees and the orange juice was 68 degrees. Both beverages did not taste cold. The meal was unpalatable due to the food temperatures. Observations were made of the mid-day meal on 6/7/10. Temperatures were taken of food held on the steam table in the kitchen and all of the food items were above 170 degrees. Trays were assembled in the facility's kitchen starting at 11:37 AM and were delivered to the units at 12:04 PM. All of the carts left the kitchen at the same time. Temperatures were taken of the food on a test tray. All of the hot food was hot, however, the milk was 60 degrees, tasted warm and was not palatable. Due to the length of time it took to deliver trays and serve meals to residents, the facility failed to serve food at acceptable temperatures making the meals unpalatable.	F 364	**Monitoring** Food temperatures of test trays will be taken weekly after the last resident is served to ensure that food and beverages remain at the proper temperatures. Dietary department will forward a copy of the food temperature records to the Quality Assurance Administrator monthly.	July 23, 2010 and monthly thereafter
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 428	**Immediate Corrective Action** Pharmacist provided facility with a copy of the one resident's review. GBHC followed up immediately with the physician. The one medication had been discontinued on 5/12/10 and the others no changes needed. **Identifying other residents having the potential to be affected** After reviewing the pharmacist process for chart audits, it was identified that there wasn't a check and balance in place. Therefore this could affect other residents having their drug regimen reviewed by the pharmacist.	June 8, 2010 June 9, 2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08E029	A. BUILDING _____ B. WING _____	C 06/09/2010

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F 428	Continued From page 13 determined that the facility failed to have a system which assure that the irregularities identified by the licensed pharmacist, during a monthly drug regimen review for one (R57) out of 37 sampled residents were reported to the E21 (attending physician) and E2 (Director of Nursing), and these reports must be acted upon. Findings include: Review of R57's monthly drug regime review log revealed that on 2/17/10 and 3/10/10, the licensed pharmacist identified irregularities. Interview with E20 (nursing supervisor) revealed that the nurse supervisor receives a copy of "consultant pharmacist monthly drug therapy evaluation form" in which the irregularities are written by the pharmacist. In addition, copy of this document is forwarded to the E3 (Assistant Director of Nursing). During this interview, it was revealed that the facility did not have a copy of the irregularities for the above two months. On 6/8/10, upon the surveyor's inquiry, the facility obtained a copy of the above forms for the two months from the pharmacist and provided a copy to the surveyor. Review of the 2/17/10 recommendation included decreasing the dose of omeprazole (medication to treat symptoms of excessive stomach acid) 20 mg. by mouth twice a day to once a day. Record review revealed that the omeprazole was discontinued on 5/12/10. The 3/10/10 recommendation included to avoid citrate of magnesia and milk of magnesia due to R57's renal impairment. Subsequent interview with E3 on 6/9/10 at approximately 10 AM revealed that unless a copy of the form is received by the facility, the facility	F 428	**Systemic Response** The pharmacist consultant continues doing the on -site chart audits on a weekly basis. Added to the process is a checklist of resident names from which the pharmacist has to indicate whose charts have been audited. This will give us our check and balance to prevent a resident's review from being missed. **Monitoring** GBHC Nursing Department will conduct an audit for compliance to the check and balance procedure. This report will be submitted to the QA committee monthly.	June 9, 2010 and ongoing June 14, 2010 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 14 does not have a system to ensure that these irregularities are acted upon.	F 428		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 08E029	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/9/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVERNOR BACON HEALTH CENTER	P.O. BOX 559 DELAWARE CITY, DE

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 166	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES

A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

This REQUIREMENT is not met as evidenced by:
Based on staff and resident interviews, and review of facility documentation, it was determined that the facility failed to ensure that resident grievances were addressed and responded to promptly for one (R84) of 37 sampled residents. Additionally, the facility failed to have a system in place to assure that resolutions to grievances were provided to residents in a timely manner. Findings include:

Review of R84's quarterly Minimum Data Set (MDS) assessment, dated 6/1/10, revealed that he was independent for cognitive skills for daily decision making and had no problem with his short-term or long-term memory.

During an interview with R84 on 6/7/10, he stated that on the previous Friday night he was served an entree that was different from what he expected. He stated that staff offered to bring him something else, so he asked what his options were, however, he stated that no one gave him an answer. He stated that when he noticed that all of the dinner trays were collected and he was still not offered a substitute, he decided to order food from a local restaurant which he had to pay for from his personal funds. He stated that he felt that the facility should have reimbursed him for the meal.

During an interview with D8 (nurse) on 6/7/10, she stated that R84 complained about his dinner on Friday night. She called down to the kitchen at about 5:20 PM and spoke to E6 (cook) who told her that she would be up to talk to the resident after her dinner break. She stated that E6 and E7 (nurse supervisor) came up to the floor at approximately 6:00 PM to talk to R84, however, the resident had already gone outside.

During an interview with E7 on 6/8/10, she stated that she went outside with E6 a little after 6:00 PM on Friday night to talk with R84 about his dinner and to find out what else they could bring him to eat. The resident stated that he had already ordered out and was waiting for his food to arrive.

During an interview with E3 (Assistant Director of Nursing) on 6/8/10, she stated that she received an e-mail from E7 regarding the problem with R84's meal and thought that the issue had been resolved. Review of the e-mail, dated 6/4/10, revealed that the resident asked to be reimbursed for the food that he paid for with his personal funds, but it did not indicate whether his request was granted.

A subsequent interview with R84 on 6/9/10, revealed that he spoke with E5 (Food Service Director) on the day after the incident and was told that he could not reimburse the resident for the food that he ordered the night before. When asked what time the cook came out to talk to him about his meal that evening, R84 stated that it was about 6:25 PM.

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 08E029	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/9/2010
NAME OF PROVIDER OR SUPPLIER **GOVERNOR BACON HEALTH CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **P.O. BOX 559 DELAWARE CITY, DE**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 166	Continued From Page 1 During an interview with E1 (Administrator) on 6/9/10, he stated that they did their best to address all residents' concerns and requests as promptly as possible, but they did not have a formal grievance process to address resident complaints. Review of the facility's policy and procedure directive entitled, "Residents' Rights and Responsibility Policy", dated 5/19/99, revealed that their "Communications" policy stated, "Every resident shall receive from the Administrator or staff of the facility a courteous, timely, and reasonable response to requests, and the facility shall make prompt efforts to resolve grievances. Responses to requests and grievances shall be made in writing upon written request by the resident." The facility failed to provide a prompt response to resolve R84's food complaint and request for reimbursement for his meal. Additionally, the facility failed to have a system and policy in place to effectively address resident grievances in a timely manner.

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Governor Bacon Health Center

DATE SURVEY COMPLETED: June 9, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey and complaint visit was conducted at this facility from June 1, 2010 through June 9, 2010. The deficiencies contained in this report are based on observations, staff and resident interviews, clinical record reviews, review of facility policies and procedures and other documentation as indicated. The facility census on the first day of the survey was eighty-seven (87). The survey sample totaled thirty-seven (37) residents.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby**	**State Reg 3201.1.2** **Plan of Correction** **General Services** Cross referenced Tags # F 279, 323, 329, 364 & 428

Provider's Signature _____ Title Director Date 7/2/10

NAME OF FACILITY: Governor Bacon Health Center

DATE SURVEY COMPLETED: June 9, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L, survey date completed 6/9/10, F279, F323, F329, F364, F428. **16 Delaware Code, Chapter 11, Sub Chapter II** **§1121 Patient's Rights (8)** **Every patient and resident shall receive from the administrator or staff of the facility a courteous, timely and reasonable response to requests, and the facility shall make prompt efforts to resolve grievances. Responses to requests and grievances shall be made in writing upon written request by the patient or resident.** **This requirement is not met as evidenced by:** Based on staff and resident interviews, and review of facility documentation, it was determined that the facility failed to ensure that resident grievances were addressed and responded to promptly for one (R84) of 37 sampled residents. Additionally, the facility failed to have a system in place to assure	**Plan of Correction** — **Completion Date** §1121 Immediate Corrective Action **Patient's Rights** The 3-11 Nurse Supervisor and cook met with the resident that evening to try to resolve the complaint. GBHC added a new type of pepper steak on the menu which the resident did not like. The cook visited the resident and offered to prepare a substitute meal. The resident declined and said he purchased food from a local restaurant. — June 4, 2010 The next day, the Food Service supervisor met with the resident to try to resolve the matter. The resident requested to be reimbursed for his meal that he had purchased. — June 5, 2010 The resident was reimbursed for his purchased meal. — June 7, 2010

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		
	that resolutions to grievances were provided to residents in a timely manner. Findings include: Review of R84's quarterly Minimum Data Set (MDS) assessment, dated 6/1/10, revealed that he was independent for cognitive skills for daily decision making and had no problem with his short-term or long-term memory. During an interview with R84 on 6/7/10, he stated that on the previous Friday night he was served an entree that was different from what he expected. He stated that staff offered to bring him something else, so he asked what his options were, however, he stated that no one gave him an answer. He stated that when he noticed that all of the dinner trays were collected and he was still not offered a substitute, he decided to order food from a local restaurant which he had to pay for from his personal funds. He stated that he felt that the facility should have reimbursed him for the meal. During an interview with D8 (nurse) on 6/7/10, she stated that R84 complained about his dinner on Friday night. She called down to the kitchen at about 5:20 PM and spoke to E6 (cook) who told her that she would be up to talk to the resident after her dinner break. She stated that E6 and E7 (nurse supervisor) came up to the floor at approximately 6:00 PM to talk to R84, however, the	**Identifying other residents having the potential to be affected**	Although no other resident was identified as having a grievance that was not resolved, all of the residents are potentially affected by this deficiency.	
		Systemic Response	Residents who have a complaint or concern (e.g. dietary, nursing, laundry, etc.) can communicate their concerns to the nurse, social worker or supervisor. The respective department head or designee will meet with the resident to listen to their concern or complaint and, if possible, address or resolve it to the resident's satisfaction. If the department head is unable to resolve the issue, he or she will notify the facility director who will meet the resident. The facility director will make a prompt effort to resolve the concern or grievance. The response will be made in writing upon written request by the patient or resident.	July 1, 2010 and ongoing
			GBHC will develop a policy outlining the process for handling residents' complaints and grievance consistent with licensing regulations and/or Delaware code.	July 19, 2010

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	resident had already gone outside. During an interview with E7 on 6/8/10, she stated that she went outside with E6 a little after 6:00 PM on Friday night to talk with R84 about his dinner and to find out what else they could bring him to eat. The resident stated that he had already ordered out and was waiting for his food to arrive. During an interview with E3 (Assistant Director of Nursing) on 6/8/10, she stated that she received an e-mail from E7 regarding the problem with R84's meal and thought that the issue had been resolved. Review of the e-mail, dated 6/4/10, revealed that the resident asked to be reimbursed for the food that he paid for with his personal funds, but it did not indicate whether his request was granted. A subsequent interview with R84 on 6/9/10, revealed that he spoke with E5 (Food Service Director) on the day after the incident and was told that he could not reimburse the resident for the food that he ordered the night before. When asked what time the cook came out to talk to him about his meal that evening, R84 stated that it was about 6:25 PM. During an interview with E1 (Administrator) on 6/9/10, he stated that they did their best to address	Monitoring	GBHC Administration will maintain a log of resident grievances/complaints referred to the facility director level. Log will forwarded to the QA Administrator.	July 19, 2010 and ongoing

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	all residents' concerns and requests as promptly as possible, but they did not have a formal grievance process to address resident complaints. Review of the facility's policy and procedure directive entitled, "Residents' Rights and Responsibility Policy", dated 5/19/99, revealed that their "Communications" policy stated, "Every resident shall receive from the Administrator or staff of the facility a courteous, timely, and reasonable response to requests, and the facility shall make prompt efforts to resolve grievances. Responses to requests and grievances shall be made in writing upon written request by the resident." The facility failed to provide a prompt response to resolve R84's food complaint and request for reimbursement for his meal. Additionally, the facility failed to have a system and policy in place to effectively address resident grievances in a timely manner.	

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